IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

LYNN SANSOUCIE,	)	
	)	
Plaintiff,	)	C.A. No. 04-861-JJF
	)	
v.	)	JURY TRIAL DEMANDED
	)	
REPRODUCTIVE ASSOCIATES OF DELAWARE, P.A.,	)	
	)	
Defendant.	)	

APPENDIX TO DEFENDANT REPRODUCTIVE ASSOCIATES OF DELAWARE, P.A.'S ANSWERING BRIEF IN OPPOSITION TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

VOLUME II OF III

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working as an embryologist in the IVF lab?

A. Yes.

Q. We've talked about ICSI a few times now. That's something else that I think you've already said you performed that?

A. Correct.

Q. As did Marc Portmann?

A. Well, I wasn't officially doing it all by myself. I would do some of the eggs.

Q. You would do some and he would do some?

A. Yes.

MR. MARTIN: Dave, just let us know when a good time for a break would be.

MR. WILLIAMS: That's fine. If you want to take a break now, that's good.

(Brief recess taken.)

BY MR. WILLIAMS:

Q. I want to circle back for a minute to something you talked about earlier. That is, the egg retrieval step in the process. Part of what you are doing is determining which eggs to preserve, which ones to use in the in vitro fertilization process. Isn't that right?

A. Not during the egg retrieval.

Q. Okay. At what point do you do that?

A. At the point after they are hyaluronidased to see which are mature and which are not. We only ICSI mature eggs. So if they are not mature, they don't get used.

Q. Okay. And I assume you are using microscopes and other technical instruments in order to examine eggs, for example?

A. Microscopes.

Q. With respect to the ICSI process, can you describe in more detail exactly what it consists of?

A. It consists of setting up a dish, a special dish, and putting needles on a microscope, and it's called manipulation because you manipulate the needle to pick up a sperm by mouth pipetting into the needle and then injecting it into an egg.

Q. And you are doing all this under a microscope?

A. Under a microscope.

Q. And what other instruments or tools are you using in performing the procedure?

A. Just really a microscope. There is a monitor hooked up to everything, but that isn't needed to do the procedure.

Q. What are some of the things that can go wrong

during the execution of that procedure which would result in either destroying the egg or not being successful in fertilizing the egg?

A. That's it.

Q. Well, are you successful 100 percent of the time?

A. No.

Q. And the extent to which you achieve success or don't achieve success depends in large part upon the skill of the person executing the procedure?

A. That helps, but that isn't a large part of it. Because human nature, nature has to take its course and fertilize the egg. You can do it correctly and the egg won't fertilize. That doesn't necessarily mean it's your fault.

Q. The more skilled you are, the higher percentage of success you will achieve. Is that a fair statement?

A. Depending on the egg quality.

Q. And improperly executed, the procedure could result in destroying the egg?

A. You can. I've never seen that, but, yes, you can.

Q. What was your success rate?

A. While I was still learning, I believe like 75 percent.

Q. And as you acquired more skill, what success rate did you achieve?

A. Well, I didn't get to do very much there at Reproductive Associates. I would do like four eggs, five eggs of a large cycle. So it's hard to tell. But what I did fertilized, you know, pretty well.

Q. Did you grade embryos to identify which embryos were the best embryos?

A. Yes.

Q. That involves the exercise of discretion, does it not?

A. Yes.

Q. Did you determine which embryos should be frozen and which should not be frozen?

A. Yes.

Q. And that also involved the exercise of discretion?

A. Yes.

Q. And judgment?

A. Yes. I wanted to add that Marc would always have to check that, though. It was never our final decision.

Q. Didn't you collaborate with each other in the IVF lab frequently?

A. What do you mean by that?

Q. Well, as two embryologists working in an IVF lab, would you collaborate with each other about various judgments that had to be exercised?

A. Yes.

Q. Consult with each other?

A. Yes.

Q. And would you agree that that kind of a collaborative approach between two embryologists working together in an IVF lab is the best approach to use and is going to achieve the best results?

A. No.

Q. You agreed earlier that Dr. Tucker is one of the leading people in the field of embryology?

A. Yes.

Q. I'm going to hand you a document that doesn't actually bear a Bates stamp. Maybe we should identify this as an exhibit, Exhibit No. 1 to your deposition.

(SanSoucie Deposition Exhibit No. 1 was marked for identification.)

BY MR. WILLIAMS:

Q. Have you seen this document before?

A. I think I had saw it in the computer at Reproductive.

Q. This was prepared by?

A. Marc.

Q. And Dr. Feinberg --

A. Oh.

Q. -- and Dr. Tucker also are attributed in this document, are they not?

A. Yes.

Q. And the document, as I understand it, talks about the fact that in smaller IVF labs where there is only a single embryologist, there is a lack of collaboration, and the objective is to create a process which in that circumstance would allow for collaborative evaluation of such issues as developing embryos. Is that right? Is that your understanding?

A. That's my understanding at Reproductive Associates.

Q. And to the extent that it's the view of Dr. Tucker and Dr. Feinberg that collaboration among and between embryologists working in a lab is a good thing, is it your testimony that you have a different professional opinion than they do?

A. Yes.

Q. And do you consider yourself to be more qualified in the field than Dr. Tucker?

A. No.

Q. Pardon me?

A. No.

Q. Do you consider yourself to be more qualified in the field than Dr. Feinberg?

A. In IVF? As to procedures, maybe, yes.

Q. So, in your view, collaboration is just either not worthwhile or actually a bad thing?

A. Yes.

Q. What happens if the wrong embryos are chosen to be frozen?

A. If the wrong embryos are chosen? Do you mean the wrong patient or the wrong -- what they look like?

Q. What they look like. The exercise of judgment and discretion as to which embryos to freeze. What happens if you exercise bad judgment and bad discretion?

A. You will -- you don't really know that. Because freezing isn't guaranteed to provide an embryo when you thaw it. A lot get lost.

Q. Well, if you freeze the wrong embryos, the net result of that at the end of the road is going to be a lower fertilization rate?

A. Right.

Q. And the objective is to have as high a rate as you can achieve?

A. Right.

Q. With respect to thawing embryos, isn't it correct that there has to be judgment and discretion exercised as to how many embryos should be thawed and when the thawing is complete?

A. Again, each place has their own, their own rules.

Q. I understand that.

But my question is: Isn't it correct that there has -- someone has to exercise judgment and discretion as to how many to thaw?

A. Yes.

Q. And when the thawing is complete?

A. When to do it, when to process the specimen?

Q. Correct.

A. Yes.

Q. And that's something you did?

A. No.

Q. You never did it?

A. I didn't decide how many to be thawed. That was the doctor's decision.

Q. When you were at Reproductive, you had contact with patients. Is that right?

A. Yes.

Q. And you have to know how to communicate the proper information to the patients in the proper way?

A. Yes.

Q. When you discover problems in the lab such as poor embryo quality or fragmentation, do you have to make a determination as to whether those are laboratory problems versus a patient problem?

A. If it -- if it became more constant, if you saw like a trend, then you would look within the lab or medication that was given to the patient or the stimulation.

Q. And that's something you were involved in trying to determine?

A. If -- yes. Yeah, I was.

Q. And that involves exercising some judgment and discretion?

A. Actually, I was told what to do. I was told what to do, how to do it.

Q. Describe what you were told?

A. If we had a problem where there was a lot of fragmentation, Marc would tell me to monitor with a probe

that he would show me how to monitor and just keep a track of temperatures for a while to see. Or we could set up mouse -- we had assays to test, so we would set up mouse assays to see if anything affected those, if the embryos died or whatever.

Q. And you performed that?

A. Yes.

Q. With respect to andrology, define what that is, first of all?

A. That's a testing of sperm.

Q. Okay. In deciding whether to freeze sperm or not to freeze it, do you have to make a determination as to whether there is enough sperm to survive a thaw of the sperm?

A. I never -- I never remember having to do that. They froze everyone's sperm that came through IVF. It was used as a backup.

Q. What does the acronym IUI stand for?

A. Intrauterine injection. They put -- I never did them. I just set them up. But I imagine -- I never even saw one, so I can't even describe it. But it was injecting the sperm into the uterus.

Q. But you have to prepare the sperm for injection?

A. Yes.

Q. And how do you do that? What are the steps in doing that?

A. Basically you would add some media to the sperm, take a count -- before you added the media, you would take a count. You would add the media, spin it down, remove -- what happens is a pellet forms on the bottom, and that's the good sperm. So remove the supernatin off the top with a pipette and then add some media, resuspend it to the bottom and count the modal sperm and the nonmodal sperm.

Q. And that processing of the sperm that you have described is all aimed at maximizing the chances of a successful procedure?

A. Yes.

Q. Define endocrine. What is that?

A. That's the running of the hormones for the -- that we run to see if they, they were ready to have a retrieval or they were ready for their IUI, and they would be given medication to raise the hormones to a certain level so they can ovulate or not ovulate and produce eggs.

Q. And you reported and reviewed the results of that?

A. I reported the ones I ran.

Q. Did you have to determine when the results or the reports -- well, when the process might need to be reviewed or rerun before reporting it to the physician?

A. If someone had -- yes.

Q. So you would have to exercise judgment as to those situations where you would want to rerun it based upon the data?

A. Well, if they had a result that was way different before, then you would. Otherwise, you really wouldn't know.

Q. With respect to drawing blood, which you did at Reproductive. Correct?

A. Yes.

Q. You have to choose an appropriate draw site. Is that right?

A. Yes.

Q. And then there are certain guidelines you have to follow in order to reduce the chances of infection and so forth. Is that correct?

A. Really reduce the chances of hematoma, which would be a big bruise, but sometimes it's unavoidable.

Q. But the degree to which the person drawing the blood is skilled will reduce the frequency of a bruise?

A. Yeah, I guess so.

Q. I mean, some people are going to bruise anyway, but improperly done --

A. Yes.

Q. -- you are going to bruise most everybody. Is that fair to say?

A. Yes. Mm-hmm.

Q. And you want to avoid that?

A. Right.

Q. And in doing the process, you have a physician test order that's kind of the starting point of the process?

A. Yes.

Q. So then you have to choose the appropriate blood draw tubes depending upon the test order?

A. Yes.

Q. Do you have to also know what order they must be drawn in order to obtain accurate specimens?

A. Yes.

Q. And, again, these are all things that you did --

A. Yes.

Q. -- at Reproductive?

And you have to understand what are the

minimum blood draw requirements, depending upon the purpose of the test?

A. Yes.

Q. You also have to process the blood?

A. Yes.

Q. What does that involve?

A. You have to put it in a centrifuge after it clots for a certain amount of time and then spin it down. And we're actually using the serum. The blood separates for the tests that we are doing. The rest of the tests get sent out.

Q. When you say after it sits for an appropriate time, you have to know how much time it has to sit or you have to observe it to make a judgment?

A. You should let it sit for 15 minutes, which isn't always done, or at least until it clots.

Q. So you have to know what you are looking at when you examine the sample in order to know whether it's been sitting long enough?

A. Yes.

Q. Are some patients prone to fainting or otherwise apprehensive about drawing blood?

A. Oh, yes.

Q. So you have to know what to do with those

people and how to handle them?

A. You call a nurse.

Q. We've already talked about this a little bit, but just briefly, let's talk about endocrine. To what extent are you exercising judgment and discretion in that process?

A. I'm not sure if there is any. You are just putting the specimen onto an instrument and the instrument is reading the results. So if your controls come in, you have to assume your results are correct.

Q. Don't you have to use discretion and judgment in order to determine the validity of the results in light of the daily, weekly, and monthly values?

A. You just have to know that your controls came in that day.

Q. What do you mean when you say you just have to know that your controls came in that day?

A. Well, then you know the specimen, as far as you know, is giving you the correct value, unless there is something way, way off. But you wouldn't really know that unless they had a result the day before that was so different.

Q. And what you're securing is what is called QC data?

A. Yes.

Q. What does that stand for?

A. Quality control.

Q. And you have to determine whether it's in an acceptable range or, on the other hand, whether you suspect that the patient results have to be rerun and not reported?

A. There was a -- yes, there was a computer program that you would put the number in and it would tell you if it's out and give you the range.

Q. What kind of instruments and equipment are you using in the lab to do this?

A. My mind is blank. They had an old instrument in there. I'm sorry, my mind went blank as to the name of the instrument.

Q. Okay. In the lab are you also performing maintenance and preventative maintenance on the instruments and equipment that you are using?

A. Yes.

Q. Weren't you also responsible for ordering supplies?

A. Yes.

Q. You had to be trained with respect to the use of various instruments in the lab, and if they get new

instruments, you have to be trained on new instruments?

A. Yes.

Q. Do you dilute patient specimens?

A. If they're high.

Q. And so you have to use judgment and discretion to know what degree you need to dilute the specimen?

A. Yes.

Q. And you did that?

A. Yes.

Q. In collecting sperm and analyzing it, was part of your training and knowledge base understanding the male physiology and what deficiencies might result in various diseases that could affect sperm counts?

A. No. I didn't have to know that to process sperm.

Q. If there was a low count, wouldn't you want to know what was causing that low count or try to determine that?

A. That wasn't really my job.

Q. Did you discuss with patients the results of testing?

A. No.

Q. You never communicated with patients?

A. Sometimes they would call to get a sperm --

their sperm count. But I didn't do that very often. That was the andrology lab.

Q. Did you ever have occasion to assist Dr. Feinberg in the operating room when he was involved in securing samples?

A. One time.

Q. What did that involve?

A. Standing in there waiting for him to hand me the tubes.

Q. What kind of sample was he securing?

A. The eggs from a patient.

Q. Was that the only sampling process that you were involved in?

A. With Dr. Feinberg, yes.

Q. And then you would examine the egg?

A. Well, that was one time. I had to take it back to the lab and then we looked at them there. It was a patient who had a problem, they couldn't get in, I think they went through the naval. They had to do it laparoscopically.

Q. When you are processing a sperm sample and it's a poor sample, I think you described this earlier, you have to spin it down in order to maximize the potential for that to result in fertilization?

A. It's done with every sample.

Q. Okay. And you have to make a decision about how much you spin it, do you not?

A. There is a set time.

Q. In all samples?

A. Yeah.

Q. Doesn't it depend on the quality?

A. If you have a really, really low count, you wouldn't spin it as hard at the same time, but you could also make a judgment to lessen it a little bit. But most of the time it's done the same.

Q. Those are judgments that you would make?

A. Right.

Q. Do you still have in front of you the resume you prepared after you left Reproductive?

A. Yes.

Q. It's the document that's marked D12 through D15.

A. That was the resume that I put on line. Right?

Q. Correct.

On page D14, where you describe your experience as an embryologist at Reproductive, embryologist and assistant lab manager, you talk about

all aspects of the ART Department. What is that?

A. Assisted reproductive technology. That's the IVF lab.

Q. That's another way to describe the IVF lab?

A. Correct.

Q. Micromanipulation of gamates, what is that?

A. That's ICSI.

Q. Including assisted hatching. What does that involve?

A. That, by the time I started doing it, was using a laser. That would just zap and hatch the egg. You would put the dish of embryo under whatever one you are going to transfer under the microscope, and a little laser circle would appear and you would put it up to the egg and hatch that area so you would just zap it. It would just -- wouldn't harm the egg, the embryo.

Q. Could you harm the embryo if you did it improperly?

A. If you put the -- put it directly on the egg, the embryo, I'm sorry, and just zapped the embryo itself, yes.

Q. There is also an instrument that's described here. What is that?

A. Tosoh. That's the one I didn't have a name

of, that I couldn't remember the name. That was the one that ran the bloods, the endocrine testing.

Q. Is it a fair reading of the resume you prepared for prospective employers to say that you held yourself out as someone who was fully trained and qualified in virtually all aspects of working in an IVF lab?

A. Yes.

Q. And held yourself out as one who had the experience and skill to do all those tasks?

A. To an extent, yes.

Q. Well, you say to an extent, yes.

Is there some reservation stated in your representation to prospective employers as to your experience and skill to perform all aspects of what might occur in an IVF lab?

A. Well, given the years of experience is how someone will go, they will determine how good you are in a lab, depending -- and that's how they will hire you, by how long you have worked in an IVF lab. So two or three years isn't someone that's really, really experienced. I may know how to do all these things, but it would be a judgment as to the person hiring you. So...

Q. Okay. So you are always learning and growing

in terms of your professional skills?

A. Yes.

Q. Is that what you are suggesting?

A. Yes.

Q. This resume is an accurate representation to the prospective employers with respect to your educational experience, background, and with respect to your work experience and with respect to your skills?

A. Yes.

Q. Did you secure a position as an embryologist?

A. Before I even put this on the Internet I did.

Q. And you have a full-time position?

A. Yes.

Q. On page D14 under personal details, what are these various, it says professional societies that you belong to?

A. These are groups that meet. ASRM is one that I belong to for embryologists where you pay a fee and you also get magazines every month. The Delaware Valley Reproductive Biologists is a group of -- it's free, and it's all people that work in IVF, and you can go and listen to lectures every, like three times a year, four times a year. PARES is another group that meets. I don't know what that stands for, but that, -- when you

want to go to the lecture, you pay for that. NCA is my certification. And United Clinical Practitioners is another one that I belong to for my certifications.

Q. And these are all professional societies?

A. Yes. And the meetings, anyone can go to them, the secretaries, the medical assistants, anyone in the -- that works in the office is allowed to attend.

Q. Did Reproductive pay membership fees to some of these professional societies on your behalf?

A. The ASRM they did. They also pay -- I'm sorry, they also paid for PARES. Like if I wanted to attend a meeting, they paid for that. It would be like a dinner meeting.

Q. And in this Society for Reproductive Medicine, there are physicians and senior-level embryologists involved in that association?

A. There is all different types of people involved in that. But the meeting that I went to would just have a dinner with a lecture.

Q. I just want to ask you about a couple things I don't think you mentioned, at least not in any detailed way, and then I'm almost done.

When an embryo is developing, did you do testing to determine whether there might be problems and

to assess the likelihood of proper development?

A. No, I didn't.

Q. At any point prior to filing this lawsuit, did you complain to Reproductive about not receiving overtime compensation at a premium rate on those occasions when you worked over 40 hours in a work week?

A. Not to Dr. Feinberg. Just among other employees.

Q. And who did you lodge such a complaint with?

A. Various people, nurses, when I would be working three weeks straight and not be able to take off on the weekend.

Q. Who did you make a complaint to and what did you say?

A. I would complain -- oh, I would complain with Linda, I would complain with Linda Morrison. I would complain with Peg Brown. I would complain with Ann Marie, who is the -- I don't know how to spell her last name. It's En-jay-in. She has a married name. In the lunchroom.

Q. What would you say?

A. Just that I'm working all these hours. It's horrible. I can't take off. If I would ask for time off or a weekend off, I would get yelled at by Marc.

Q. So you complained about the hours you were working?

A. Yes.

Q. My question is: Did you complain to any supervisor to the effect that you should be paid at a premium rate if you worked for in excess of 40 hours in a work week?

A. I couldn't. I couldn't. I was actually in fear when I worked there of Marc. I didn't want to lose my job.

Q. Did you lodge the complaint that I have just described to anyone, apart from just saying I'm working a lot?

A. No. No.

Q. You never communicated any complaint to Dr. Feinberg?

A. No.

Q. What records did you keep with respect to the hours that you worked?

A. I had a calendar that I had made copies of. And the other was my bridge toll when I would go through the Delaware Memorial Bridge.

Q. Are you saying that you have records that have been produced reflecting the hours that you worked?

A. Yes.

Q. What did you record on your calendar specifically?

A. Days worked, basically, and various times, times that I went in earlier, like I would go in at 6:30 or 6:00.

Q. And you would record each of those events on your calendar?

A. Yes. Yes.

Q. And it's your testimony that you never left early, you never took a long lunch, you never took compensatory time off or professional time off?

A. You are saying never. I --

Q. Well, I'm trying to repeat what I understood your testimony to be. If it's inaccurate, tell me.

A. I never took a long lunch. Towards the end of my employment there, I made a couple dental appointments in the morning and would come in an hour or two late, which I put on the calendar, which they should have a record of because it's in their computer. And I didn't take all of my vacation that I was allowed to take because when we were up in cycle, I wasn't allowed to have off. And if I did ask for a day off, I would be made to feel like I was going to be yelled at.

So the answer to that is I took some, but not a lot, not what I was entitled to. And I never took a long lunch. I very rarely left the building. They must be mistaking me for the other worker that works there.

Q. Who is they? I'm not sure who you are referring to.

A. Reproductive. I know they had said I took long lunches.

Q. When you received the e-mail from Dr. Feinberg which is D32 --

A. Yes.

Q. -- and he told you that you were going to be paid a salary of 62,500, that represented an increase in salary or in annualized compensation for you compared to your prior employment?

A. Yes.

Q. And paragraph 3 of his e-mail told you that there would be occasions when weekend laboratory work would be required as part of the job?

A. Yes.

Q. And that's because in this fertilization process, once it starts, there has to be an ongoing monitoring process and so forth throughout the entire

process, you can't just take a weekend off.

A. You do need someone there, one person there.

Q. And so when you received this e-mail from Dr. Feinberg, you didn't raise with him a question about additional compensation above and beyond your annualized salary if you worked on weekends?

A. When I got this, I didn't think that I would be working 21 days straight without a day off. You can work a weekend and have a day off during the week.

Q. So it was your understanding that you would work no more than five days in a work week?

A. Yes.

Q. And did you confirm that understanding in any way with Dr. Feinberg?

A. No.

Q. After you arrived, you just never raised the issue?

A. No.

Q. And how long did you work there?

A. I complained about working the weekends in IVF and andrology. But I got -- I got really -- I got yelled at for that by Marc Portmann. So I learned to not say anything more.

Q. When did you leave?

A. February of last year.

Q. After you left and prior to the time that you filed this lawsuit, did you lodge any complaint with Dr. Feinberg or Marc Portmann or anyone else at Reproductive in a position of authority with respect to asserting a claim for overtime compensation?

A. No.

Q. You did lodge with Marc Portmann and others complaints, other kinds of complaints about Marc Portmann, did you not, after you left and before you filed this lawsuit?

A. I responded to an e-mail from someone that I was in contact with, and we both complained.

Q. I am handing you a document that is identified as D46 through D49 and ask if you can tell me what that is?

A. They make this up at Reproductive, they made it up, and it's people -- our duties and job skills for the function we are doing, what's required of us.

Q. You saw this document?

A. Yes.

Q. And as of 11/13/2001, you were there as a full-time employee?

A. I think it was 2001, yes. I believe so, yes.

Q. This document accurately describes your job?

A. Except for the Bachelor's degree.

MR. MARTIN: And you are referring to all three pages or four pages?

MR. WILLIAMS: Correct.

MR. MARTIN: All right. I ask that she be given an opportunity to carefully review that.

THE WITNESS: I don't think this is the original one, because PGD testing wasn't even being done in 2001. So I think this was done when they -- remade when they did their CAP certification. This doesn't look like the one that I read. I might have the original.

BY MR. WILLIAMS:

Q. My question is, that you responded to earlier, is does it accurately describe your job?

A. Yes.

Q. And let me hand you a document that's marked D50 through D53 and ask whether this document is a document that you are familiar with?

A. This one looks more -- let me finish reading it. Okay.

Now, what was your question again on this?

Q. First of all, are you familiar with the

document?

A. This one looks more familiar, but I can't say for certain that it's -- it's the one that I've read.

Q. To the extent that you worked in the andro/endo lab, does this document accurately describe your responsibilities?

A. Yes.

Q. I am handing you a document that's entitled RAD Lab Training Protocol that's marked as D20 through -- I'm sorry, D200 through D218.

Are you familiar with this document?

A. I never saw this.

Q. Okay. I have no questions about it if you never saw it.

And I am handing you a document that's identified as D82 through D99 titled The in Vitro Fertilization Program, Patient Information and Consent Forms.

Are you familiar with this document?

A. I never saw this either.

MR. WILLIAMS: I think I'm almost done, or close to it. Let me just take a break for a few minutes.

(Brief recess taken.)

MR. WILLIAMS: I just have a few more questions and we're all done.

BY MR. WILLIAMS:

Q. I'm putting before you a document that is a record of salary payments, it's D36, D35 and D36. I asked you about this earlier. But you were employed on a part-time basis and then became a full-time employee. It looks like that occurred in June of 2001. Does that sound right?

A. Yes.

Q. And at that point the salary that you started with, which was 62,500, was paid in equal monthly installments. It looks like that amounted to $5,200, at least at the outset. Does that square with your recollection?

A. Yes.

Q. So your gross pay was that amount per month, and your net pay was 4,579.17?

A. Yes.

Q. So that's in excess of payment at a rate of a thousand dollars plus a week?

A. Yes.

Q. And then it looks like your salary went up at the beginning of 2002. Do you see that --

A. Yes.

Q. -- increase?

And it appears that 5,417, and the number jumped around a little bit in the early months, but that that amount, and maybe that has something to do with deductions, but that that amount would have been the equal monthly installment of whatever your annualized salary was as it was increased at that point?

A. Yes.

Q. And that you were paid at at least that rate through the balance of your employment with Reproductive? You didn't receive any decreases?

A. No.

Q. One thing that perhaps is already clear, but maybe not. As I understand the way the andro/endo lab worked in conjunction with the IVF lab, would it be fair to say that mistakes in the andro/endo lab would have an effect upon the IVF lab because everything was kind of interrelated?

A. Yes.

Q. This document does not have an identification on it, but as I understand, it was produced by your counsel. It appears to be an EZ-Pass record?

A. Yes.

Q. You referred earlier with respect to information that you might have with respect to the hours and days that you worked that the EZ-Pass records would be part of that puzzle. Is that right?

A. Yes.

Q. And that's what you are referring to?

A. Yes.

Q. And you have produced all the relevant EZ-Pass records?

A. As far as I know.

Q. To the best of your knowledge?

A. Yes.

Q. Provided them to your counsel?

A. Yes.

Q. And I am handing you what appears to be a calendar, and these do have numbers, 22 through 26.

And just for clarity of the record, the document that I handed you earlier is numbered 46 through 57?

A. Yes.

Q. That's at least a portion of the calendars that you refer to?

A. Yes.

Q. If I place before you documents which also are

calendars that are numbered 27 and 28, are those your calendars or copies of portions of your calendar?

A. Yes.

Q. To the best of your knowledge, do we have copies of all of the relevant portions of your calendar? By relevant, I mean the ones that relate to the number of days or hours that you worked at Reproductive?

A. Yes.

Q. And it looks like I have a lot of additional EZ-Pass, I'm not sure what these are, maybe you can identify them. They look like they are printed off a computer screen. But they are numbered 58 through 145. Tell me what they are?

A. These are when I called EZ-Pass and asked the supervisor to print up all my going through the tolls if he could. And this is what he sent me.

Q. And, to the best of your knowledge, that covers the time period that you worked at Reproductive?

A. Yes.

Q. The entire time period?

A. I believe pretty much of it.

Q. On those occasions when you did not work a 40-hour work week, whether it was because you were sick or you had a dentist appointment or you took a vacation

day, or whatever the reason was, you continued to be paid at the same salary level despite that absence, did you not?

A. Not for the vacation day. That was deducted from my vacation time. I was allotted certain vacation days and sick days.

Q. But your monthly salary was not reduced?

A. No, because I used those days.

Q. Like most employees, you didn't have an unlimited number of days of vacation, you had a certain number of days of vacation you could take?

A. Correct.

Q. And you described at least one occasion when you came in a few hours late because of a dental appointment. There was no deduction from your pay for that, was there?

A. No.

Q. Were there any other occasions when for whatever reason you came in late or left early? And were there -- I think you said earlier that you don't think there were occasions like that other than the one occasion. Is that --

A. Right before I left I went to a funeral, right before I was fired, and I came in the next day and that's

when I was fired and also resigned. But I didn't -- well, I was supposed to get paid for the rest of the month, and I didn't get paid.

Q. That was the day before you resigned?

A. Fired and resigned, yeah. I also had a week's vacation coming to me, which I had scheduled for May, which I wasn't able to take before that.

Q. You did submit a resignation, did you not?

A. Well, I was called in to be fired, and at the same time they fired me I said, that's good because I was going to resign anyway. And they said, that's good , because that will make our job easier. But we will pay you until the end of the month. You need to leave right now.

Q. So the answer to my question is, you did submit a written resignation?

A. After I was called in to be fired, yes.

Q. You testified about this, but just to get it in the record, and these are not identified at this point, I would ask that they be identified, the first is The Fate of Non-Transferred Embryos After Day 3 Assisted Hatching. And the other is Contribution of -- maybe you better pronounce those terms because I will trip over them.

A. Do you want me to read that?

Q. Yes.

A. Contribution of Blastocyst Cryopreservation to Cumulative IVF Success.

Q. I think you referred earlier to the fact, and I think I asked you as to whether you were attributed as one of the contributors to these scientific materials. Are these the documents that we were both referring to in that discussion?

A. Yes.

MR. WILLIAMS: Can we mark those as 2 and 3.

(SanSoucie Deposition Exhibit Nos. 2 and 3 were marked for identification.)

BY MR. WILLIAMS:

Q. And, finally, I know we talked about this earlier, but I'm still not sure I understand it. In my profession there are certain very specific requirements in order to become a member of the profession or to be certified, and I'm not sure I entirely understand what is required in order to obtain the various certifications you have obtained.

We talked about the medical technologist, for example. What do you have to do

educationally or otherwise in order to obtain the certification and what ongoing requirements, if any, are there to maintain it?

A. You need to take a, it's an exam, a Board certification, which I did. And then you need to keep up with, in order to keep it going, you need to provide them with continuing education.

Q. Who prepares the exam?

A. The government. It's a government exam for each state, I believe.

Q. And it is a technical exam that tests your knowledge of skills and information relevant to the field of medical technology?

A. Yes.

Q. And then you have continuing education requirements in order to --

A. Yes.

Q. -- preserve the certificate?

To what extent? How many hours?

A. I'm not sure of the amount of hours. They send it every, I believe it's every two years. And meetings and papers and different things count for that. And I'm not sure of the exact amount that you need, but it is pretty much like 30.

Q. Like 30 hours a year?

A. I think, CEU's, continuing education credits.

Q. So you have done that?

A. Yes.

Q. And the MLT, which is, as I recall, medical lab technician --

A. Yes.

Q. -- certification, is that the same process? Is there a certification test administered and then requirements of continuing education in order to maintain the certificate?

A. That's just what it's called, MLT, medical lab technician. That's what you are called when you work in a lab. It's a name.

Q. Well, in your resume you described it as a certification?

A. Well, the CLT is the certification for that. MLT CLT.

Q. They are interchangeable? Is that what you are saying?

A. Yes. Yes.

Q. Why did you list both of them?

A. Actually, it's not interchangeable, it's a whole -- you are an MLT, but then you need a

certification. It could be ASEP, it could be CLP. There is a couple other ones. HEW.

Q. But MLT is a certification?

A. That's when you finish the school, you can be an MLT, but then you need to take a test to be certified, and then that gives you the certifying of whatever you choose. You could be certified in HEW, you can be certified in ASEP. It's a registry that you have to take.

Q. When you say finish school, what do you mean by finish school?

A. When you go through the amount of college credits required. You are required 60 for an MLT.

Q. And you did that at Hahnemann?

A. I did most of it there.

Q. And then you finished up at Rowan?

A. I went to Rowan, and then I did some more. I mean, I have been continuing all over trying to get my college credits.

Q. Is it harder to be certified as a medical technologist than it is to be certified as an MLT?

A. No, it's just a matter of having a B.S., getting the college credits. It's no different.

Q. And CLT, is that a subset of MLT certification

or is it a separate and distinct certification?

A. It's really separate. MLT isn't really a certification, it's the program that you went to and that's what you end up being.

Q. CLT is a certification?

A. Yes.

Q. In that you have to take a test?

A. Yes.

Q. And tell me again what that acronym stands for?

A. Clinical lab technician.

Q. And who administers and prepares the exam?

A. It's a national certification agency. It's done by the government. I had to go into Pennsylvania to take it. They have state testing sites for Boards, they are called Boards --

Q. It's not --

A. -- through Washington. I know it comes out of Washington.

Q. Doctors also are Board certified. Is it the same --

A. Like that.

Q. -- concept?

A. I would believe. I'm not really sure.

Q. Is the same true of CLP?

A. No. That I just had to send in my, all my transcripts. That wasn't an exam I had to take.

Q. And are there requirements, are there requirements in order to maintain that status?

A. Just the fee every year.

Q. How about A.S.?

A. No, that's an Associate's. That's from your college credits.

Q. I'm just confused why you listed that under the category certifications?

A. It's not really a certification. It's just my mistake.

Q. What is your estimate as to the overtime that you are owed?

A. I think I averaged it out to 51 hours a week.

Q. Is that a guess?

A. Well, I did an average. Sometimes it was even more. It depended -- it depended how long we were in the lab that day. At least until noon or 1 o'clock from being there at 6:00 in the morning. So that's being kind of stingy.

Q. In order to do the averaging, did you prepare a week-by-week analysis of how many hours you think you

worked in each work week?

A. I started writing it down according to -- I think there was one paper where I started averaging it out trying to figure it out and we came up with that number, I came up with that number. It's not exact. It's kind of on the low end.

Q. Well, I guess maybe I didn't ask the question well, but is there a worksheet somewhere that you prepared that goes week by week or month by month?

A. The calendar that I had handwritten and the tolls, the toll, it says when I went through and came back out.

Q. Did you review all those documents and then come up with a worksheet for each week which identified the number of hours you believe you worked in each week?

A. I did to my best of my knowledge. I tried, yes.

Q. So you have a worksheet somewhere where you went through those documents and for each week identified the number of hours you believe you worked?

A. Yes.

Q. Has that worksheet been produced?

A. I think some of it was, yes. You don't have it?

MR. MARTIN: I don't know. Because I did not do it with her. So I will look for it, Dave, and let you know.

MR. WILLIAMS: And can I ask the witness, if you haven't provided it to your counsel, to provide it to your counsel.

THE WITNESS: Sure, I will.

MR. WILLIAMS: I have no further questions.

MR. MARTIN: Thank you.

(Deposition concluded at 12:59 p.m.)

(Presentation, reading and signing of the deposition transcript was waived by the witness.)

Electronic Embryo Evaluation (EEE) — Are 2 heads better than 1?

[1]M Portmann, [2]M Tucker, [1]BA McGuirk, [1,3]RF Feinberg. [1]Reproductive Associates of DE, Newark, DE. [2]Georgia Reproductive Specialists, Atlanta, GA. [3]Dept. Ob/Gyn, Yale Univ., New Haven, CT.

Objective

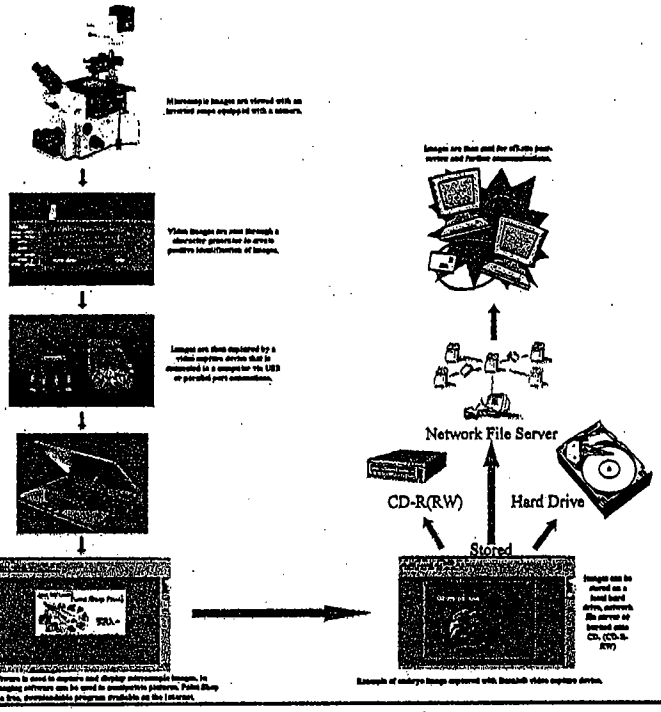
Embryo morphologic assessment is vital for successful outcomes in all ART programs. For smaller IVF centers committed to minimizing multiple pregnancy risk, a single embryologist is often challenged with the task of identifying the highest quality embryos for transfer. Thus, we instituted a relatively inexpensive, yet effective electronic system for collaborative evaluation of developing embryos prior to uterine transfer, and have determined the impact of this initiative on implantation rates in our program.

Design

Images of developing embryos were electronically transferred by the Embryologist to the off-site Laboratory Director for collaborative evaluation prior to embryo transfer. A consensus recommendation was provided to the patient following laboratory and clinical assessment. Based on this information, the patient made the final decision regarding number of embryos to be transferred.

Materials and Method

Electronic embryo evaluation EEE was carried out prior to uterine transfer in 78 fresh cycles and 15 frozen-thaw cycles during a 17-month period from October 1999 to February of 2001. Video images of embryos were digitized using a Snappy Video Snapshot (Play Incorporated Ver. 3.0) connected to a laptop computer. Images were then archived onto CD-RW disks using an external CD-RW drive. To ensure correct identification of embryo images, a character generator was positioned between the microscope camera and Snappy Video Snapshot to embed patient names and dates onto archived pictures. Images were taken on the morning of day 1 after insemination and continued each day at approximately the same time up until day 6. Embryo morphological characteristics were recorded each day.



Materials and Method (cont.)

The morning of embryo transfer, embryo images were sent via electronic mail to the off-site laboratory director. Embryo grading was evaluated by the off-site Laboratory Director and Embryologist. All transfers were carried out by the same physician.

Results

	With EEE	Without EEE	P Value
Avg. Embryos Per Transfer	3.2	3.4	N.S.
Clinical Pregnancy Rate	56% (42/75)	34% (28/83)	0.09
Ongoing/Delivered Pregnancy Rate	41% (31/75)	24% (20/83)	0.25
Embryo Implantation Rate	24% (58/238) *	13% (35/281)	0.01
Multiple Pregnancy Rate	36% (9/42 twins, 6/42 triplets)	32% (5/28 twins, 4/28 triplets)	

* ($p < 0.05$)

* The higher implantation rate with EEE was statistically significant ($p < 0.05$).

Conclusions

As nationwide demand for assisted reproduction steadily increases, both new and smaller IVF laboratories will strive for quality assurance. In this setting, the embryologist is responsible for culturing embryos with high implantation potential. This goal has been addressed in our Center by successfully utilizing a collaborative electronic embryo evaluation system. In the near future, real-time video microscopy may provide off-site IVF Lab Directors further opportunities to assess egg and embryo quality, and to teach and critique specific techniques.

The Fate of Non-Transferred Embryos After Day 3 Assisted Hatching

Marc Portmann MT, MHA [1], Lynn SanSoucie MLT [1], Linda Morrison MLT [1], Michael Tucker PhD, FIBiol [2], Barbara McGuirk MD [1], Ronald Feinberg PhD, MD [1,3].

[1] Reproductive Associates of Delaware, Newark, DE; [2] Georgia Reproductive Specialists, Atlanta, GA; [3] Yale Univ, New Haven, CT.

59th Annual Meeting of the American Society for Reproductive Medicine - October 2003 – San Antonio, Texas

Objective

To determine if assisted hatching (AH) on day 3 affects blastocyst formation in non-transferred (NT) penultimate embryos.

Design

Retrospective analysis of 84 IVF cycles in which remaining NT embryos were observed following day 3 fresh transfer. Blastocyst formation rates were compared in day 3 AH embryos versus those without day 3 AH.

Materials and Method

Oocytes were retrieved in HTF (InVitrocare), hyaluronidased after 2 to 3 hours incubation and ICSI'ed following cumulus-corona removal. Oocytes were placed in Q1 (InVitrocare) after ICSI and cultured individually in this media until Day 3. Embryos were placed into CCM (VitroLife) on the morning of Day 3 for extended culture. Morphologic assessment occurred on Day 2, 3 5 and 6. The best embryos were identified and assisted hatched on the morning of day 3 - 2 to 3 hours prior to transfer. A minimum of 1 and maximum of 7 embryos were selected as best and AH'ed per patient. Non-hatched, non-transferred embryos along with AH'ed but non-transferred embryos were placed in extended culture and observed for blast formation. Blastocysts were cryopreserved on Day 5, 6 or 7. All transfers occurred on Day 3 using a Wallace 23cm stylet (Irvine) and Cook Echotip Catheter (Cook OB/GYN) under abdominal guidance.

Results

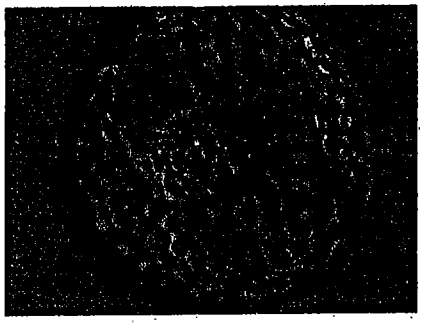
In the 84 cycles analyzed, 191 fresh embryos were AH and transferred (avg. 2.3 embryos/transfer), yielding a clinical implantation rate of 42% and ongoing PR of 67%. Among the remaining 602 NT embryos, 437 were non-AH, and 165 had day 3 AH. All NT embryos were observed until day 7. 61 of 165 (37%) AH embryos developed to blastocysts, whereas 130 of 437 (30%) of non-AH embryos yielded blastocysts, a statistically significant difference (Chi Square: p = 0.0019).

Cycles w / Assisted Hatched / Non-Transferred Embryos	84
Total Embryos Produced	793
# Embryos Transferred	191
Total Embryos Undergoing AH	356
Assisted Hatched but Not Transferred	165
AH / not transferred / but frozen	61
% Blast Formation	37% *
Not hatched / not transferred	437
Not hatched / not transferred / but frozen	130
% Blast Formation	30% *

* p = (0.0019)

Conclusions

AH on day 3 of non-transferred (NT) penultimate embryos – i.e. those remaining after fresh transfers – did not appear detrimental based on blastocyst formation rates. Interestingly, AH may have even been beneficial, based on a statistically higher blastocyst rate in the AH group compared to non-AH embryos. This effect could be due to: 1) Selection bias on NT embryos picked for AH 2) An intrinsic benefit of AH upon nutrient ion exchange or 3) A permissive effect leading to enhanced spatial relationships between dividing blastomeres. Prospective analysis is needed to better analyze these possibilities.



Contribution of Blastocyst Cryopreservation to Cumulative IVF Success

M. P. Portmann [1], L. T. SanSoucie [1], M. J. Tucker [1], M. C. Brown [1], B. A. McGuirk [1], R. F. Feinberg [1,2].

[1] Reproductive Associates of Delaware, Newark, DE; [2] Georgia Reproductive Specialists, Atlanta, GA; [3] Yale Univ, New Haven, CT.

Objective

Extended embryo culture to the blastocyst stage has shown promise for enhancing implantation rates while reducing the risk of multiple gestation in many patients. Nevertheless, universal acceptance of this strategy has not occurred. In order to evaluate the potential role of extended embryo culture in our center, we utilized blastocyst cryopreservation for non-transferred day 3 embryos, and have evaluated the impact of this approach upon implantation rates and cumulative success.

Design

Retrospective analysis of 135 consecutive patient outcomes following embryo transfer with fresh and/or thawed blastocysts was assessed over a 24 month treatment interval. Survival and implantation competence of thawed blastocysts was determined.

Materials and Method

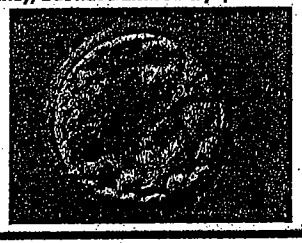
Oocytes were initially placed into HTF (InVitrocare) after retrieval. If normally inseminated, oocytes remained in HTF until day 1 after retrieval after which they were placed into Q1 (InVitrocare) after fertilization assessment for culture until day 3. If injected, oocytes were placed into Q1 immediately following ICSI and cultured until day 3. On the morning of day 3, embryos were rinsed well and placed into CCM (VitroLife) for extended culture to Day 7. Morphologic assessment occurred on day 2, 3, 5 and day 6. Embryos were assisted hatched on day 3 prior to transfer. All transfers were carried out using a Wallace 23cm stylet and Cook Echotip ET catheter under abdominal ultrasound guidance.

Materials and Method (cont.)

Blastocysts were frozen in two steps using modified HTF plus 20% HSA as the base medium: 5% Glycerol for 10 minutes followed by 10% Glycerol with 0.2M sucrose with immediate loading of embryos. Blastocysts were thawed stepwise through decreasing concentrations of glycerol and sucrose (10% Glyc + 0.4M Suc., 5% Glyc + 0.4M Suc., 2.5% Glyc + 0.4M Suc., 0.4M Suc., 0.2M Suc., 0.1M Suc., modified HTF) for 3 minutes each.

Results

135 consecutive patients in the cohort (mean age: 34.4; range: 23-45) have undergone, at time of abstract submission, 156 transfers of fresh embryos (mean 2.9 embryos per transfer) and 29 transfers of thawed blastocysts (mean 2.7 blastocysts per transfer). Forty-three percent of the cohort (58/135) have had non-transferred embryos cryopreserved as blastocysts; of the 58 patients with blastocysts frozen, 25 patients accounted for 29 blastocyst thaw cycles. Survival and implantation competence of thawed blastocysts were calculated, along with the impact of these pregnancies on cumulative success in the patient cohort. (See Table). Fourteen percent of the cohort (19/135) have not achieved a pregnancy, but have unused cryopreserved blastocysts.



# Blast Thaw Cycles	29
# Blasts Thawed	103
# Blast Survived	84
% Survival	82%
Ongoing Thaw PR / Transfer	45% (13/29)
Implant Rate / Thaw	30% (24/79)
Ongoing Fresh PR / Transfer	48% (76/156)
Implant Rate / Fresh	28% (128/459)
Cumulative Clinical PR / Patient	81%* (110/135)
Cumulative Ongoing / PR / Patient	66%* (89/135)

*At time of abstract submission

Conclusions

Extended culture and cryopreservation of non-transferred day 3 embryos has had a positive impact for patients in our center, by increasing the ongoing cumulative pregnancy rate in a consecutive cohort of patients. The majority of non-pregnant patients from this cohort remain in treatment. High blastocyst thaw survival rates have resulted in encouraging implantation and ongoing pregnancy rates for our center. Evaluating extended culture outcomes for non-transferred day 3 embryos provides an important quality assurance "stepping stone" for centers considering fresh blastocyst transfers.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

LYNN SANSOUCIE,	:	
	:	
Plaintiff,	:	
	:	
v.	:	C.A. No. 04-861-JJF
REPRODUCTIVE ASSOCIATES OF DELAWARE, PA.	:	
	:	
Defendant.	:	

AFFIDAVIT OF MARC PORTMANN, M.T., B.S., M. H. A.

STATE OF DELAWARE :
: SS.
NEW CASTLE COUNTY :

BE IT REMEMBERED that on this 14th day of February, 2005, personally appeared before me the Subscriber, a Notary Public for the State and County aforesaid, MARC PORTMANN, who being duty sworn according to law, did depose and say as follows:

1. I am employed by Reproductive Associates of Delaware, P.A. ("RAD") as an Embryologist and Laboratory Manager. I have personal knowledge of the facts stated below.

2. RAD provides medical care and fertility treatment for couples attempting pregnancy in a variety of infertility settings. RAD employs approximately 20 employees, including two physicians and directors, Ronald Feinberg, M.D., and Barbara

McGuirk, M.D., two embryologists, a laboratory specialist, two nurse practitioners, two medical assistants, patient coordinators, and additional staff.

3. RAD offers its patients several different fertility treatments using assisted reproductive technology. RAD also operates three on-site laboratories: the Andrology Laboratory for preparing and processing sperm, the Endocrine Laboratory for analyzing and quantitating hormone levels in the blood, and the *In-Vitro* Fertilization Laboratory ("IVF lab").

4. The work performed in each lab is critical to the overall success of an assisted reproduction procedure. An error or misjudgment in one lab can be fatal to the entire procedure for couples waiting months, or even years, to attempt pregnancy through assisted reproduction technology.

5. While the type of fertility treatment chosen by patients usually depends upon their particular diagnosis, the most commonly practiced methods at RAD are *Intrauterine Insemination* and *In-Vitro Fertilization.*

6. *Intrauterine Insemination* ("IUI") is a type of artificial insemination which involves placing a sterile catheter containing sperm through the cervix and injecting the sperm directly into the uterus. With IUI, the healthiest sperm are placed into the female genital tract to increase the likelihood that one of the sperm will fertilize an egg. IUI is therefore very helpful for patients experiencing low sperm count or motility. IUI is less invasive than *in-vitro* fertilization, however, it does not allow the physician to view whether fertilization is capable of taking place. With *in-vitro* fertilization, fertilization can be confirmed because it takes place outside of the body.

7. *In-Vitro* Fertilization ("IVF") generally involves retrieving

IN THE UNITED STATES DISTRICT COURT

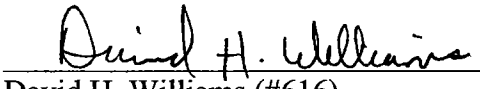
FOR THE DISTRICT OF DELAWARE

LYNN SANSOUCIE,	)	
	)	
Plaintiff,	)	C.A. No. 04-861-JJF
	)	
v.	)	JURY TRIAL DEMANDED
	)	
REPRODUCTIVE ASSOCIATES OF DELAWARE, P.A.,	)	
	)	
	)	
Defendant.	)	

CERTIFICATE OF SERVICE

I hereby certify that on March 14, 2005, I electronically filed **APPENDIX TO DEFENDANT REPRODUCTIVE ASSOCIATES OF DELAWARE, P.A.'S ANSWERING BRIEF IN OPPOSITION TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT** with the Clerk of Court using CM/ECF which will send notification of such filing(s) to the following:

Jeffrey K. Martin, Esquire
Margolis & Edelstein
1509 Gilpin Avenue
Wilmington, DE 19806



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Dated: March 14, 2005